

MARYLAND DEPARTMENT OF THE ENVIRONMENT
 Land Management Administration • Technical Services and Operations Program
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 410-537-3314 • 800-633-6101 x3314 • <http://www.mde.state.md.us>

Notification of Special Medical Waste Activity

THIS SECTION IS FOR OFFICIAL USE ONLY																																							
COMMENTS																																							
C																																							
C																																							
INSTALLATION'S ID NUMBER															APPROVED					DATE RECEIVED																			
																				YEAR					MONTH					DAY									
C																																							
F																																							
I. NAME OF INSTALLATION																																							
II. MAILING ADDRESS OF INSTALLATION																																							
STREET OR P.O. BOX																																							
C																																							
3																																							
CITY OR TOWN																				STATE					ZIP CODE														
C																																							
4																																							
III. LOCATION OF INSTALLATION																																							
PLACE NAME																																							
STREET OR ROUTE NUMBER																																							
C																																							
5																																							
CITY OR TOWN																				STATE					ZIP CODE														
C																																							
6																																							
IV. INSTALLATION CONTACT																																							
NAME AND TITLE															AREA CODE + PHONE NUMBER																								
C																																							
2																																							
V. OWNERSHIP																																							
NAME OF INSTALLATION'S LEGAL OWNER																				TYPE OF OWNERSHIP																			
C																																							
R																																							
VI. TYPE OF REGULATED WASTE ACTIVITY (MARK "X" IN THE APPROPRIATE BOXES.)																																							
SPECIAL MEDICAL WASTE ACTIVITY															FIRST OR SUBSEQUENT NOTIFICATION																								
<input type="checkbox"/> 1. GENERATOR <input type="checkbox"/> 2. TRANSPORTER <input type="checkbox"/> 3. TREATOR/STORER/DISPOSER															<input type="checkbox"/> 1. FIRST NOTIFICATION <input type="checkbox"/> 2. SUBSEQUENT NOTIFICATION (COMPLETE ITEM 3) <input type="checkbox"/> 3. TREATOR/STORER/DISPOSER																								
VII. CERTIFICATION																																							
I CERTIFY UNDER PENALTY OF LAW THAT I HAVE PERSONALLY EXAMINED AND AM FAMILIAR WITH THE INFORMATION SUBMITTED IN THIS AND ALL ATTACHED DOCUMENTS, AND THAT BASED ON MY INQUIRY OF THOSE INDIVIDUALS IMMEDIATELY RESPONSIBLE FOR OBTAINING THE INFORMATION, I BELIEVE THAT THE SUBMITTED INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I AM AWARE THAT THERE ARE SIGNIFICANT PENALTIES FOR SUBMITTING FALSE INFORMATION, INCLUDING THE POSSIBILITY OF FINE AND IMPRISONMENT.																																							
SIGNATURE															NAME AND OFFICIAL TITLE										DATE SIGNED														